LAW, ETHICS AND MEDICINE

Simple rationality? The law of healthcare resource allocation in England

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This paper examines the law relating to healthcare resource allocation in England. The National Health Service (NHS) Act 1977 does not impose an absolute duty to provide specified healthcare services. The courts will only interfere with a resource allocation decision made by an NHS body if that decision is frankly irrational (or where the decision infringes the principle of proportionality when a right under the European Convention on Human Rights (ECHR) is engaged). Such irrationality is very difficult to establish. The ECHR has made no significant contribution to domestic English law in the arena of healthcare provision. The decision of the European Court in the Yvonne Watts case establishes that, in relation to the question of entitlement to seek treatment abroad at the expense of the NHS, a clinical judgment about the urgency of treatment trumps an administrative decision about waiting list targets. That decision goes against the grain of domestic law about healthcare allocation, but is not likely to have wide ramifications in domestic law.

The English law relating to the allocation of healthcare resources is a game of forensic ''pass the parcel''. No one wants to decide, and no one wants to be seen not to want to decide. The law in this area is a set of legislative and judicial ruses to ensure that the music keeps on going until the decision is back in the hands of the Trust.

THE STATUTORY FRAMEWORK

Section 1(1) of The National Health Service (NHS) Act 1977 imposes on the Secretary of State a duty: ''to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of those countries, and (b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with the Act''.

Section 3 is more explicit about what the duty under section 1 involves. It says that the Secretary of State must: ''…provide …to such extent as he considers necessary to meet all reasonable requirements… (e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; (f) such other services as are required for the diagnosis and treatment of illness''.

Section 13 of the Act allows the Secretary of State to direct a regional health authority to exercise the Secretary's functions under sections 1 and 3, and the Secretary of State has made such a direction in the past.[1] The legal mechanics of the subsequent delegation to NHS Trusts are complex and for these purposes are irrelevant.[2] It is enough to say that such Trusts are the hands of the Secretary of State for the purpose of performing the Secretary's obligations under sections 1 and 3.

There have been attempts to say that sections 1 and 3 of the 1977 Act impose on the Secretary of State an absolute duty to provide specified healthcare services. Those attempts have always failed.[3] This is not surprising. There are three reasons why the courts have refused to construe them as imposing an absolute obligation.[4] First, section 1 does not oblige the Secretary of State to *provide* a ''comprehensive health service'', but only to continue to *promote* such a service. Second, section 3 limits the Secretary of State's obligation to an obligation to provide facilities ''to such extent as he considers necessary to meet all reasonable requirements''. Third, the obligation under section 3(e) is simply to provide ''such facilities… as he considers are appropriate…''. This is not the language of absolutism. The apparent absolutism of section 3(f) cannot transmute the relativism of the previous subsections into absolute duties.

What, then, is the extent of the Secretary of State's duties under the 1977 Act? It has been set out very clearly:

> When exercising his judgment [the Secretary of State] has to bear in mind the comprehensive service which he is under a duty to promote as set out in section 1. However, as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening either section 1 or section 3. The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the

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Abbreviations: ECHR, European Convention on Human Rights; NHS, National Health Service

> ever-increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand.[5]

This judicial realism underpins all decisions in the arena of resources.[6] One gets the impression that even if the 1977 Act apparently imposed an absolute duty, the judges, reluctant to acknowledge that Parliament could have told the Secretary of State to do the impossible, would have found a way to dilute the duty.

CHALLENGING DECISIONS ABOUT RESOURCE ALLOCATION

The basic public law position

The law is very simple. The courts will not interfere with a decision about how money is allocated unless that decision is frankly irrational.[7–9] This is the ubiquitous public law rule.[10] Where rights under the European Convention on Human Rights (ECHR) are engaged, proportionality is also a criterion.[11–12] Because none of the English resource allocation cases to date has been decided on the basis of ECHR considerations, it is difficult to know how the courts would approach the proportionality criterion in this context. As the courts have sidelined the ECHR, it is likely that they would find that looking at the issue through the lens of proportionality added little or nothing to the view given by the traditional irrationality test. Irrationality is difficult to show. Three broad propositions govern the way the court looks at such cases:[13]

> 1. A health authority can legitimately, indeed must, make choices between the various claims on its budget when, as will usually be the case, it does not have sufficient funds to meet all of those claims.''
> 2. In making those decisions the authority can legitimately take into account a wide range of considerations, including the proven success or otherwise of the proposed treatment; the seriousness of the condition that the treatment is intended to relieve; and the cost of that treatment.
> 3. The court cannot substitute its decision for that of the authority, either in respect of the medical judgments that the authority makes, or in respect of its view of priorities.

Being rational (or not irrational), does not necessarily mean having a set of inflexibly applied policies arrived at in the well-minuted meetings of constitutionally impeccable committees. A policy of providing a particular treatment in unspecified ''exceptional circumstances'' will not necessarily be unlawful. Indeed it ''…will be rational in the legal sense provided that it is possible to envisage, and the decision-maker does envisage, what such exceptional circumstances might be.[14i] The failing of the Swindon NHS Primary Care Trust in the Herceptin litigation was not that it had a policy of providing Herceptin in exceptional circumstances, but simply that it was unable to point to the exceptional circumstances that would cause it to fund the prescription of Herceptin. A decision to spend the money otherwise spent on Herceptin on other clinical demands would have been perfectly rational and defensible, but the Trust had expressly said that it did not take finances into account in making its decision about Herceptin.[15]

This judicial passivity has frustrated many. Some judges have tried to make funding decisions more justiciable. In Bull v Devon Area Health Authority[16] (a case involving allegedly inadequate provision of staffing for the postnatal care of a brain-damaged baby, damaged by delay in delivery), the issue of resource allocation did not arise directly for decision, but Mustill L J commented that the courts might not be able to dodge the issue for ever. He noted that other public services cannot necessarily escape liability by complaining that their unsafe systems were a consequence of sadly inadequate funding.[i] So far, however, the courts have dodged this issue in a medical context without difficulty or apparent intellectual embarrassment.

CHALLENGING DECISIONS ABOUT RESOURCE ALLOCATION: THE EFFECT OF THE HUMAN CONVENTION ON HUMAN RIGHTS

The Human Rights Act 1998 effectively grafted the ECHR into domestic law.[ii] Some hoped and some feared that it would radically change medical law. The hopes and the fears have proved groundless.[17–19iii]

Four Articles of the ECHR feature in debates about resource allocation: Articles 2, 3, 8 and 14. The English courts have consistently found that these Articles add nothing to domestic law. The Court of Appeal in the Herceptin litigation did not even bother to deal in their judgment with the ECHR points that had been raised.

Article 2 provides that ''Everyone's right to life shall be protected by law…''. The European Court of Human Rights has held that this sentence ''enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction''.[20] At first glance, this might seem to be a useful weapon in the armoury of someone contending in a medical context that the state has not released sufficient funds to ''safeguard the lives'' of its citizens, but the Court went on to say that this positive obligation ''must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities''.[20a] There is no example in any medical context of the Article demanding more of the NHS than the domestic law does.

Article 3 prohibits ''torture or….inhuman or degrading treatment''. It is well established that this can impose a positive obligation on a contracting state to take measures to ensure that the right is protected. [21–23] It has sometimes been argued that failure to make provision for medical treatment amounts to a breach of the Article, but in England this argument has been given short shrift. In the North West Lancashire HA case, Buxton said: ''Article 3 of the ECHR addresses positive conduct by public officials of a high degree of seriousness and opprobrium. It has never been applied to merely policy decisions on the allocation of resources… That is clear not only from the terms of Article 3 itself, and the lack of any suggestion in any of the authorities that it could apply in a case even remotely like the present, but also from the explanation of the reach of Article 3 that has been given by the Convention organs''.[24]

Article 8, subject to some important exceptions in 8(2), guarantees the ''right to respect for….private and family life''. It is a very elastic Article that can stretch into most areas of life.[26] Again, it can impose positive obligations, but again, the Court of Appeal in the North West Lancashire case decided that it could not dictate a positive obligation to provide treatment: ''…in this case there has occurred no **interference** with either the applicants' private life or with their sexuality. The ECHR jurisprudence demonstrates that a state can be guilty of such interference simply by inaction, though the cases in which that has been found do not seem to go beyond an obligation to

[i] The same point was made by Pill LJ in Knight v Home Office.[31]

[ii] The exact nature and the mechanism of the importation of the ECHR into English law are complex and for these purposes irrelevant.

[iii] This has been regretted by some.[32 33]

adopt measures to prevent serious infractions of private or family life by subjects of the state… Such an interference could hardly be founded on a refusal to fund treatment''[26] (original emphasis). Article 14 prohibits discrimination in the application of ECHR rights.[iv] It is inconceivable that a decision about treatment funding that fell foul of Article 14 would not also be irrational and therefore unlawful in domestic law.

Underlying all these curt judicial dismissals of rights-based arguments is the idea that there is no right to distributive justice. The House of Lords could hardly be clearer:

> Human rights are the rights essential to the life and dignity of the individual in a democratic society. The exact limits of such rights are debatable and, although there is not much trace of economic rights in the 50-year old Convention, I think it is well arguable that human rights include the right to a minimum standard of living, without which many of the other rights would be a mockery. However, they certainly do not include the right to a fair distribution of resources or fair treatment in economic terms – in other words, distributive justice. Of course, distributive justice is a good thing, but it is not a fundamental human right. No one looking at the legal systems of the member states of Council of Europe could plausibly say that they treated distributive justice as a fundamental principle to which other considerations of policy or expediency should be subordinated.[27]

It could be argued that the expression ''distributive justice'' is being used rather inaccurately here, and indeed that by supporting rational refusals to allocate resources for a particular purpose, the courts are really maintaining the overall size of the fund available for NHS patients as a group, so promoting, rather than inhibiting, distributive justice. By saying that distributive justice ''is not a fundamental human right'', all that the House of Lords is really saying is that an individual patient does not have an enforceable right to put their own hand into the public purse and take out what they happen to need.

The effect of European Community law

The European Court of Justice ruled in the Yvonne Watts case that the NHS must refund patients who are forced to seek treatment abroad for medical conditions because of undue delay in the provision of that treatment in the NHS. The mere fact that NHS treatment would have been provided by an NHS waiting time target did not mean that no undue delay had occurred. The European Court referred the case back to the domestic court to decide whether in fact an undue delay had occurred. Importantly, it said that a proper decision about what amounted to undue delay would be a clinical rather than a merely administrative one:[28]

> A refusal to grant prior authorisation [for medical treatment abroad] cannot be based merely on the existence of waiting lists intended to enable the supply of hospital care to be planned and managed on the basis of predetermined general clinical priorities, without carrying out an objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the request for authorisation was made or renewed. Where the delay arising from such waiting lists appears to exceed an acceptable time having regard to an objective medical assessment of the abovementioned circumstances, the competent institution may not refuse the authorisation sought on the grounds of the existence of those waiting lists, an alleged distortion of the normal order of priorities linked to the relative urgency of the cases to be treated, the fact that the hospital treatment provided under the national system in question is free of charge, the obligation to make available specific funds to reimburse the cost of treatment to be provided in another Member State and/or a comparison between the cost of that treatment and that of equivalent treatment in the competent Member State.[29]

This has been billed in the lay press as a widely repercussive case about resource allocation. It certainly goes against the grain of domestic UK law in allowing clinical judgment in an individual case to trump presumably rationally reached administrative decisions about waiting lists (decisions that presumably purport to balance the other conflicting clinical and financial priorities), but it is unlikely to colour the English courts' general approach to resource allocation[v].[30] It is a very technical case about the construction of two Articles of European legislation.[vi] It has no application to any issue other than that of waiting lists, and it is only relevant to that issue if the patient applies to have treatment abroad. If a Trust decided to provide treatment X but not treatment Y, the Watts case would give no grounds at all for challenge.

CONCLUSION

We live in a world where there is limited money and infinite suffering. In such a world, the bottom line of all judicial thinking about healthcare resource allocation is that there is no enforceable individual right to a particular treatment. This is likely to be the rock on which subsequent attempts to force really significant changes in NHS funding are likely to founder. Although individual decisions about resource allocation are ethically difficult and emotionally agonising, they are legally undemanding. A defensible decision is merely a rational one. The authorities indicate that it is fairly easy to be rational, or at least not sufficiently irrational to give grounds for challenge.

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[iv] Article 14 provides: ''The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status''.

[v] The general attitude of the English courts in resource allocation cases to attempts to use European Directives to widen general principles of domestic law is shown well in R (on the application of Pfizer Ltd) v Secretary of State for Health.[31]

[vi] Article 22 of Regulation 1408/71 and Article 49 of the EC Treaty. The question of whether other contracting states have similar obligations to their nationals which they could discharge by paying for treatment abroad, so effectively requiring contracting states which do not otherwise have a publicly funded healthcare system to pay for one, is a complex one, which is outside the scope of this paper.

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